

Summary Statement

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US House of Representatives

Committee on Energy and Commerce, Subcommittee on Health

Hearing on "Insuring Bright Futures: Improving Access to Dental Care and Providing a Healthy Start for Children"

My testimony today reflects the totality of my experience. It is based on three facts:

- first, that tooth decay is overwhelmingly preventable;
- second, that dental care is essential to children's overall health and wellbeing; and
- third, that dental care is cost effective.

All three qualities have strong implications for your Committee's oversight of Medicaid and the State Child Health Insurance Program.

Medicaid dental coverage for children as envisioned by Congress is tremendously valuable, appropriately designed, and fully accountable. The handful of states that have implemented Medicaid dental coverage well have demonstrated that this program works for children, their families, and their caregivers. But in the majority of states, Medicaid dental coverage is little more than an unfulfilled promise – adequate coverage but inadequate services. Congress has many options to further strengthen dental Medicaid performance across the nation through improved oversight; incentives and sanctions, federal grants to states for program improvements, and beneficiary empowerment by granting legal standing to beneficiaries when the program fails them.

Just as the mouth is integral to the body, so too must dental care be legislated as an integral component of well baby and well child care. With SCHIP reauthorization now underway, Congress can take steps to stabilize and improve dental coverage in SCHIP by requiring that it provides both dental preventive and dental treatment services. Congress can enact "wrap around" dental coverage in SCHIP for those children from working-poor families who have medical but no dental coverage and it can require dental performance information from states so that they are accountable to both the federal government and to the children.

The fact that dental care is prevention oriented, essential to children's health, and cost effective also makes it a very favorable healthcare service from a public insurance perspective. A small upfront investment in comprehensive dental care for all children would pay considerable dividends in both health outcome and dollars saved. But effective preventive dental care requires that children receive care early and periodically in a dental home – an identified source of ongoing care that provides complete oversight and care coordination for each child.

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Good morning. My name is Burton Edelstein. I am a pediatric dentist who first cared for a child with Medicaid coverage 37 years ago – just three years after Congress mandated dental services for children in Medicaid. Since that time I have been actively engaged in Medicaid and SCHIP as a private practice clinician in Connecticut, as a dental educator now at Columbia University, and as founder of the Children's Dental Health Project – a DC-based independent policy organization committed to improving children's oral health in America.

I have learned about publicly financed dental coverage from my patients and their families, from students and colleagues, and from working with Congress and the Department of Health and Human Services. I have also observed much from the public's response to the tragic and completely avoidable death of Deamonte Driver, the Maryland 12 year old who died just up North Capitol Street from here at National Children's Medical Center from complications of a dental infection. Sadly, Deamonte represents the worst case scenario of multiple systems failures. I dedicate my testimony to him and to the hundreds of thousands of other children who suffer significantly and unnecessarily from preventable dental problems.

My testimony today reflects the totality of this experience. It is based on three facts:

- first, that tooth decay is overwhelmingly preventable;
- second, that dental care is essential to children's overall health and wellbeing; and
- third, that dental care is cost effective.

All three qualities have strong implications for your Committee's oversight of Medicaid and the State Child Health Insurance Program.

Regarding Medicaid: Medicaid dental coverage for children as envisioned by Congress is tremendously valuable, appropriately designed, and fully accountable. The handful of states that have implemented Medicaid dental coverage well have demonstrated that this program works for children, their families, and their caregivers. But in the majority of states, Medicaid dental coverage is little more than an unfulfilled promise – adequate coverage but inadequate services. Congress has many options to further strengthen dental Medicaid performance across the nation through improved oversight; incentives and sanctions, federal grants to states for program improvements, and beneficiary empowerment by granting legal standing to beneficiaries when the program fails them.

Regarding SCHIP: In the aftermath of Deamonte's death which so clearly demonstrated that the teeth and mouth are an integral part of the body, dental coverage can no longer be considered an "optional service" in SCHIP. Just as the mouth is integral to the body, so too must dental care be legislated as an integral component of well baby and well child care. With SCHIP reauthorization now underway, Congress can take steps to stabilize and improve dental coverage in SCHIP by requiring that it provides both dental preventive and dental treatment services. Congress can enact "wrap around" dental coverage in SCHIP for those children from working-

poor families who have medical but no dental coverage and it can require dental performance information from states so that they are accountable to both the federal government and to the children.

The fact that dental care is prevention oriented, essential to children's health, and cost effective also makes it a very favorable healthcare service from a public insurance perspective. A small upfront investment in comprehensive dental care for all children would pay considerable dividends in both health outcome and dollars saved. But effective preventive dental care requires that children receive care early and periodically in a dental home – an identified source of ongoing care that provides complete oversight and care coordination for each child. For example, if Deamonte Driver had had a dental home starting with the recommended age-one dental visit, his disease may well have been prevented through health education and counseling, fluoride treatments, and placement of dental sealants. Had this level of treatment been insufficient and he still developed cavities, they would have been found early and treated at low cost. Rather than a quarter million dollar bill to Maryland Medicaid for neurosurgery, he could have been treated with a sealant, a filling, or, if necessary, an extraction – any one of which would cost the state less than \$150 dollars.

Dental disease matters: Ordinary tooth decay needs no longer be the single most common chronic disease of childhood in America. As a nation, we can reach our elusive Healthy People 2010 goals for children's oral health and can reverse the recent upswing in tooth decay reported by CDC for our youngest children. CDC reported in August of 2005 that more than a quarter (28%) of 2-5 year olds already have cavities in their baby teeth and half (49%) of children ages

6-11 have cavities in their adult teeth. Toothaches that distract from eating, sleeping, and attending to schoolwork are completely preventable and – when they do occur – are completely treatable at low cost. Dental abscesses that lead to swollen faces like that shown in the photograph before you, and even to head and neck infections that can proceed to cause significant morbidity and occasional mortality are similarly avoidable – and when they occur – treatable at low cost. Yet many children insured through Medicaid seek relief of toothaches in the emergency rooms of our community hospitals because of difficulty accessing dental care in private and safety-net offices. One Texas study reported that the cost to Medicaid is three times greater for emergency room care – care that doesn’t solve the underlying dental problem - than the total cost of preventive care would have been to assure oral health in the first place¹.

Dental coverage matters. Federal data confirm that children with dental coverage, whether in Medicaid, SCHIP, or employer-based insurance, obtain more dental care than similarly situated children without coverage. Yet Medicaid and SCHIP have not realized their full potential in most states as far fewer children in these programs are able to access care than children in commercial coverage. According to the most recently available CMS data on Medicaid program performance, only 30 percent of children enrolled in Medicaid at any time during the year had at least one dental visit and only 25 percent had at least one preventive dental visit – less than half the rate of services obtained by commercially insured children. State-by-state performance varies greatly – ranging as low as 13 percent in one state to as high as 47 percent in another. We know far less about SCHIP effectiveness because Congress has not to date required systematic dental performance reporting in SCHIP.

Effective Medicaid and SCHIP dental coverage matters. According to a HRSA report, young children in poor and working poor families (<200% FPL) eligible for Medicaid and SCHIP are five times more likely to have cavities than children in higher income families (>300% FPL). They have three times more teeth decayed and are twice as likely to seek a dental visit for pain relief - but are only half as likely to obtain a dental visit in a year. These disparities can be well addressed by effective SCHIP and Medicaid administration in the states and by working collaboratively with families, dentists, and government to ensure that the program meets diverse needs and constraints.

Prevention matters: CDC promotes prevention programs including community water fluoridation that continues to effectively dampen decay experience in America and sealant programs that protect permanent teeth that are most susceptible to decay – like the tooth that ultimately led to Deamonte’s demise. The Maternal and Child Health Bureau’s focus on the oral health of young children in Head Start and on children with special health care needs promotes early and timely prevention. NIH-sponsored research over the past 40 years has well established that tooth decay is an infectious disease that is typically transmitted from mothers to children during a child’s first years of life. This and other scientific knowledge about the nature of the disease provide a number of options for “providing a healthy start” for all children through universal acceptance of the age-one dental visit, parent and provider education, and regular dental care in a dental home. Lacking only in these federal programs is sufficient support, coordination, and dissemination of best practices to realize tremendous financial and health returns for our children.

Global perspective: Childhood tooth decay is a global problem. Pediatric oral health activists in the US from inside and outside of federal government have recently engaged in a global campaign to reduce childhood tooth decay through both prevention and treatment approaches. With sufficient ongoing Congressional attention to dental care for our children – particularly for those who are eligible for Medicaid and SCHIP – the US can set the standard of good oral health for children and can become the international leader among the 11 participating nations that represent half of the world’s child population.

On behalf of America’s children, I urge you and your Committee to continue attending to pediatric oral health, to maximize opportunities for cost-effective cavity prevention, to ensure that dental care is never again considered optional in SCHIP, and to integrate oral health into each and every federal program that addresses the health and welfare of our nation’s children. You have before you many policy options and opportunities for “improving access to dental care and providing a healthy start for children.” My colleagues and I look forward to your questions today and to providing ongoing assistance in your efforts to ensure “bright futures” for all children.

Thank you.

¹ Pettinato ES, Webb MD, Seale NS. A comparison of Medicaid reimbursement for non definitive pediatric dental treatment in the emergency room versus periodic preventive care. *Pediatric Dentistry*, 2000